Components Of A Family Planning Chart Review: Would You Chart Stand-Up To Scrutiny?

Satellite Conference
Thursday, November 10, 2005
2:00-4:00 p.m. (Central Time)

Produced by the Alabama Department of Public Health
Video Communications Division

Faculty

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Program Objectives

- **Emphasize the importance to chart review in quality assurance.**
- **Discuss benefits to the chart review process.**
- **Identify components of a chart review.**

Program Objectives

- **Discuss how to develop an auditing system that will identify your documentation strengths and weaknesses.**
- **Review a sample chart review form.**
- **Demonstrate through written example exercises the chart review process.**

- **"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional qualities."**

  –IOM, 1990 *Medicare: A Strategy for Quality Assurance*

- **"demonstrate that the quality of patient care was consistently optimal by continually evaluating care through reliable and valid measures."**

  –JACHO 1975 *Quality of Professional Services Std*

Quality Assurance

- Championed by JACHO
- Measure of institutional function
  - Designed to detect variations
  - Is variation acceptable or unacceptable?
- Establish clinical indicators
- Identify situations needing peer reviews
  - Deficiencies
  - Remedial action/outcomes

Quality Assurance

- There can always be improvement
- Quality cannot be determined by one case
- No further action
- Corrective action

Format

- Identify
  - Variation
  - Specific problem
  - Opportunity to improve care/performance
- Formulate a plan
- Record of actions taken

Format

- Documentation
  - Expectations for change
  - Measurement
  - Follow-up
  - Institutional reporting
- Legal consultation

Applying Risk Prevention Documentation to Everyday Practice

Documentation

- Good medical care
- Minimizes chance for miscommunication
- Legal defense
  - Standard of care
  - Careful, thorough care
  - Poor documentation
    - Careless
    - Force settlement
    - Serious harm

Major Principles

- Accuracy
- Comprehensiveness
- Legibility
- Objectivity
- Timeliness

Accuracy

- Use standard method
- Special circumstances
- Consistent in word usage
- Accepted and agreed upon abbreviations
- Time, date and legible signature

HEALTH ASSESSMENT RECORD

VISIT TYPE

CD__ CH__ DM__ FP__ HTN__ PP__ STD__ WIC__

REASON/COMMENTS _____

PHALCON LABEL

Name _____

Date of Service _____

CHR # _____

DOB _____

ALLERGIES: _____

MEDICATIONS (HERBAL SUPPLEMENTS): _____

EKG: _____

OB/GYN UPDATE:

LMP _____ Problems _____

BC Method_____ Problems _____

Date Douched_____ Date last pregnancy _____

STD UPDATE:

Past STD's_____

CHILD/ADOLESCENT HEALTH/UPDATE:

Lead Risk Status: High _____ Low _____

Reason, if high: _____

Developmental Assessment: P __ F (category/s!) _____

Anticipatory Guidance done per protocol Yes ___ No ___

If not, why: _____

Comprehensiveness

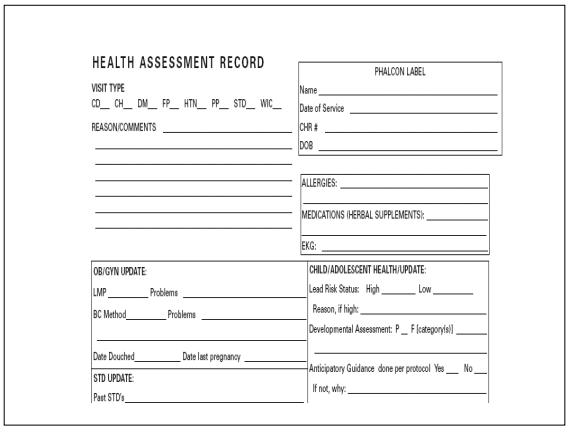
- Identification
- Current condition
- Past medical history
- Past surgical history
- Family history
- Social history
- Medications
- Physical examination

Comprehensiveness

- Initial assessment and reassessment
- Results
- Operative reports
- Procedure notes
- Consultant reports
- Informed consent

Comprehensiveness

- Counseling and education
- Disposition
- Patient correspondence
- Advanced directives



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CHILD/ADOLESCENT HEALTH/UPDATE:
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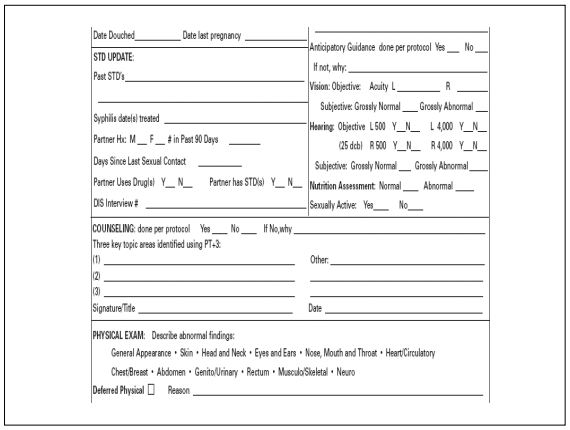
Reason, if high: _____
Developmental Assessment: P _ F (category/s!) _____
Anticipatory Guidance done per protocol Yes ___ No ___
If not, why: _____



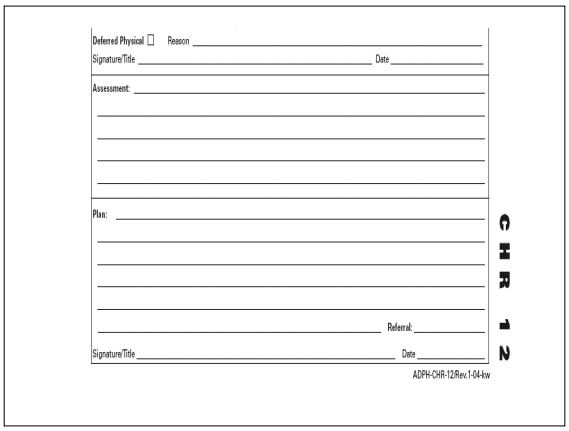
Date Douched _____ Date last pregnancy _____

STD UPDATE:
Past STD's _____
Syphilis date(s) treated _____
Partner Hx: M__ F__ # in Past 90 Days _____
Days Since Last Sexual Contact _____
Partner Uses Drug(s) Y__ N__ Partner has STD(s) Y__ N__
DIS Interview # _____

Anticipatory Guidance done per protocol Yes ___ No ___
If not, why: _____
Vision: Objective: Acuity L _____ R _____
Subjective: Grossly Normal ___ Grossly Abnormal ___
Hearing: Objective L 500 Y__N__ L 4,000 Y__N__
(25 dcb) R 500 Y__N__ R 4,000 Y__N__
Subjective: Grossly Normal ___ Grossly Abnormal ___
Nutrition Assessment: Normal ___ Abnormal ___
Sexually Active: Yes___ No___

COUNSELING: done per protocol Yes ___ No ___ If No,why _____
Three key topic areas identified using PT+3:
(1) _____ Other: _____
(2) _____
(3) _____
Signature/Title _____ Date _____

PHYSICAL EXAM: Describe abnormal findings:
General Appearance • Skin • Head and Neck • Eyes and Ears • Nose, Mouth and Throat • Heart/Circulatory
Chest/Breast • Abdomen • Genito/Urinary • Rectum • Musculo/Skeletal • Neuro
Deferred Physical ☐ Reason _____



Deferred Physical ☐ Reason _____
Signature/Title _____ Date _____

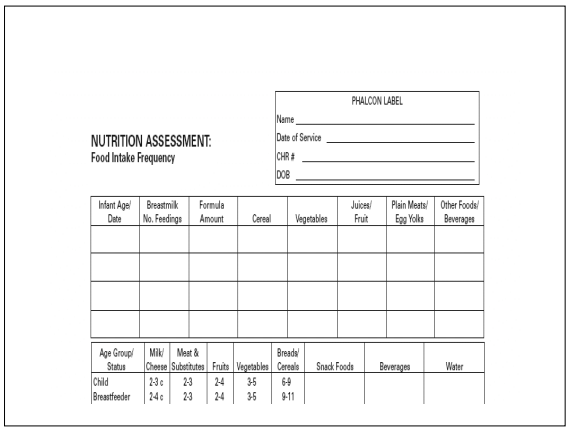
Assessment: _____

Plan: _____

Referral: _____
Signature/Title _____ Date _____

CHR 1-2

ADPH-CHR-12/Rev.1-04-kw

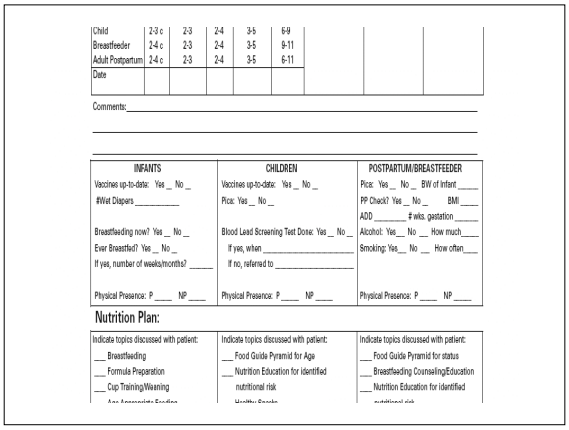


NUTRITION ASSESSMENT:
Food Intake Frequency

PHALCON LABEL
Name _____
Date of Service _____
CHR # _____
DOB _____

Infant Age/ Date	Breastmilk No. Feedings	Formula Amount	Cereal	Vegetables	Juices/ Fruit	Plain Meats/ Egg Yolks	Other Foods/ Beverages

Age Group/ Status	Milk/ Cheese	Meat & Substitutes	Fruits	Vegetables	Breads/ Cereals	Snack Foods	Beverages	Water
Child	2-3 c	2-3	2-4	3-5	6-9			
Breastfeeder	2-4 c	2-3	2-4	3-5	9-11			



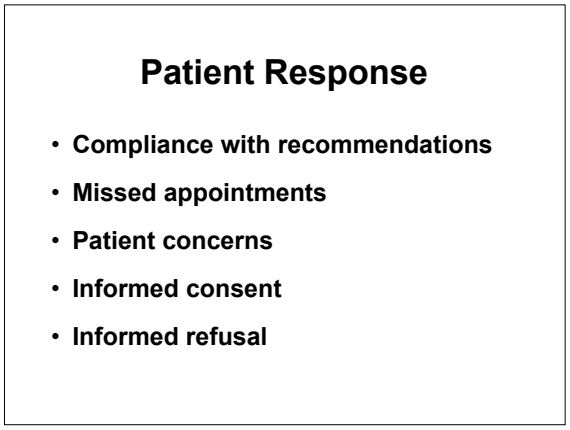
Child	2-3 c	2-3	2-4	3-5	6-9			
Breastfeeder	2-4 c	2-3	2-4	3-5	9-11			
Adult Postpartum	2-4 c	2-3	2-4	3-5	6-11			
Date								

Comments: _____

INFANTS	CHILDREN	POSTPARTUM/BREASTFEEDER
Vaccines up-to-date: Yes __ No __	Vaccines up-to-date: Yes __ No __	Pics: Yes__ No __ BW of Infant ____
#Wet Diapers _____	Pics: Yes __ No __	PP Check? Yes __ No __ BMI ____
		ADD _____ # wks. gestation _____
Breastfeeding now? Yes __ No __	Blood Lead Screening Test Done: Yes __ No __	Alcohol: Yes__ No __ How much____
Ever Breastfed? Yes __ No __	If yes, when _____	Smoking: Yes__ No __ How often___
If yes, number of weeks/months? _____	If no, referred to _____	
Physical Presence: P ____ NP ____	Physical Presence: P ____ NP ____	Physical Presence: P ____ NP ____

Nutrition Plan:

Indicate topics discussed with patient:	Indicate topics discussed with patient:	Indicate topics discussed with patient:
___ Breastfeeding	___Food Guide Pyramid for Age	___ Food Guide Pyramid for status
___ Formula Preparation	___ Nutrition Education for identified nutritional risk	___ Breastfeeding Counseling/Education
___ Cup Training/Weaning		___ Nutrition Education for identified nutritional risk
___ Age Appropriate Feeding	___ Healthy Snacks	



Patient Response

- **Compliance with recommendations**
- **Missed appointments**
- **Patient concerns**
- **Informed consent**
- **Informed refusal**

Legibility

- Wastes valuable time
- May reflect sloppy/inadequate care
- Misinterpretations

Objectivity

- Relevant facts
- Do not criticize
- Do not resolve differences
- Avoid judgmental words

Timeliness

- Record events when they occur
- Review results in timely fashion
- Develop policy

Quality Assurance

- Information evaluated
- Alternatives considered
- Recommended treatment
- Reasoning
  - Diagnosis
  - Choosing treatment
  - Deviating from the standard of care
  - Deviating from consultant's recommendations

IF IT'S NOT WRITTEN,
IT DID NOT HAPPEN!!!

Patient Satisfaction Problems

- Communication failures
- Poor patient/staff/doctor interaction
- Lying or covering up
- Conflicting information
- Lack of information on transfer
- Breaching a confidence
  - Pichert, Miller, et al JQI, 1998

Poor Communication Strategies

- Standing
- Use of technical vocabulary
- Domination of the conversation
  - Fails to acknowledge the patient
  - Not intended
  - Doctor isn't listening
  - Helpful to health professional

Good Communication

- Posture
  - Sitting
  - Appropriate body language/tone
- Words to use and not to use

SOAP

- Subjective
  - "Quotes"
  - Capacity
- Objective
  - Chaperones
  - Avoid judgments
- Assessment/Opinion
  - Rule out or likely
- Plan
  - Follow-up
  - Referral
  - Access
  - Agreement

- Subjective: 41-year-old white female states, "I felt a lump on my right breast yesterday." Lump is nontender without pruritus, bleeding or nipple discharge. No associated fevers, chills, fatigue, weight change, hot flashes, back or joint pains. No personal or family history of breast cancer. Menarche at age 13, mother of three, first born at age 22, all breast fed to age 1 without problems. Normal LMP three weeks ago, contraception via condoms, infrequently performs BSE, drinks three to five cups of coffee daily, nonsmoker. No other concerns today.

- Objective: Chaperoned exam by nurse A.C. BP, 120/70; P=66; RR=14; T=99.2 oral; weight=138 lbs. Lungs clear bilaterally, Heart RRR, no palpable vertebral tenderness or spinal deformity. Breast without skin color or texture change, no retractions. Left breast without nodularity or expressed discharge. Right breast with 1.5 cm, mobile, smooth-bordered, rubbery, nontender lesion at 10 o'clock. No other lesions. No nipple discharge. No axillary lymphadenopathy bilaterally.

- Opinion: Right breast lump. Specific diagnosis unclear. History and exam favor fibrocystic change. Rule out malignant involvement.
- Options: Reviewed observation with re-examination through full menstrual cycle vs. ultrasound with possible biopsy. Symptomatic treatments reviewed including caffeine reduction and hormonal stabilization with OCPs.

- **Advice: Advised ultrasound characterization now with possible follow-up investigations including biopsy and/or excision. Tripartite nature of breast cancer reviewed. Encouraged annual screening mammography and reviewed its diagnostic limitations. Instructed BSE. Reminded patient she is due for lipid profile.**
- **Agreed Plan: Patient chooses ultrasound now. Radiology appointment scheduled. She understands need for close follow up and states she'll keep appointments. Recheck in one week. Dictated in patient's presence.**

Effective Communication

- **Accept patient's perspective**
- **Respond to concerns**
- **Use verbal/nonverbal communication**
- **Be nonjudgmental**
- **Engage patient in discussion**
- **Convey comfort**
- **Abandon stereotypes**

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- **Implementing and maintaining effective patient tracking and follow-up systems.**
- **Establishing and following clinic polices and procedures.**
- **Improving patient relationships.**

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- **Establishing effective communication with patients and families.**
- **Improving medical record documentation.**
- **Avoiding disagreement among health care providers.**

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- **Following applicable practice guidelines.**
- **Hiring qualified staff and supervising them.**
- **Maintaining patient confidentiality.**
- **Avoiding medication errors.**

Components of a Family Planning Chart Review

Objectives

- **Evolution of quality assurance.**
- **Discuss program development.**
- **Review screening tools.**

Accessibility of care: The ease with which patients can obtain the care they need when they need it

Appropriateness of care: The degree to which the correct care is provided, given the current state of knowledge

Continuity of care: The degree to which the care needed by patients is coordinated among practitioners and across organizations and time

Effectiveness of care: The degree to which care is provided in the correct manner—ie, without error, given the current state of knowledge

Efficacy of care: The degree to which a service has the potential to meet the need for which it is used

Efficiency of care: The degree to which the care received has the desired effect with a minimum of effort, expense, or waste

Patient-perspective issues: The degree to which patients and their families are involved in the decision-making processes in matters pertaining to their health, and the degree to which they judge care to be acceptable.

Safety of the care environment: The degree to which the environment is free from hazard or danger.

Timeliness of care: The degree to which care is provided to patients when they need it.

Clinical practice guideline recommendations: Pain should be assessed and documented routinely at regular intervals postoperatively, as determined by the operation and the severity of pain (eg, every 2 hours while awake for 24 hours after surgery).

Medical review criterion: For the patient recovering from surgery, the patient's pain was assessed and documented every 2 hours while awake for the first 24 hours following surgery.

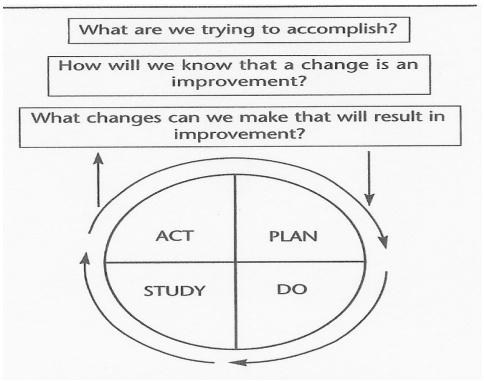
Performance measure: Calculate the following for consecutive surgical patients seen over a 6-month period: the number of patients whose pain was assessed and documented every 2 hours while awake. The performance measure is:

$$\frac{\text{number of cases with criterion met}}{\text{number of surgery cases}} \times 100\%$$

Standard of quality: A performance rate of 95% or less triggers a review to determine how to improve assessing and documenting the patient's pain status every 2 hours while awake for the first 24 hours postoperatively.

Avedis Donabedian, MD

- **Structure**
  - **Staffing**
  - **Equipment**
  - **Space**
- **Process**
  - **Direct observation**
  - **Medical record**
- **Outcomes**
  - **Results/intervention**



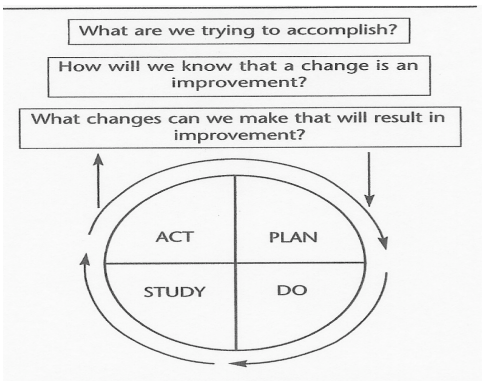
PLAN:	State the objectives of the cycle. Make predictions about what will happen and why. Develop a plan to carry out the change (Who? What? Where? What data need to be collected?).
DO:	Carry out the test. Document problems and unexpected observations. Begin analysis of the data.
STUDY	Complete the analysis of the data. Summarize what was learned.
ACT:	What modifications should be made? What will happen in the next cycle?

Abbreviations

- **A progress note read, the AAFP patient in with mother for Depo Provera. This was not a recognized medical abbreviation nor was it approved for use according to the facility policy.**

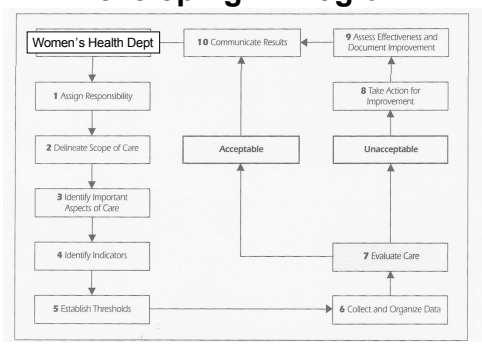
Best Practices

Use medical terminology and only use abbreviations approved by your facility.



Characteristic	Quality Improvement	Traditional Risk Management
Purpose	Ensure that quality of care is optimal; evaluate practitioner performance and protect patients	Minimize the hospital's losses; protect hospital
Character	Educational/remedial	Crisis intervention
Function	Measure actual care against guidelines; when care does not meet guidelines, take remedial action	Detect risks to the hospital, then prevent the recurrence or minimize their effect when they do occur
Patients Involved	Single patient or group of patients, discharged or still hospitalized; patterns or recurrent problems in patient care are assessed	Single patient, discharged or hospitalized; isolated events are assessed
Time Frame	Usually retrospective or concurrent with patient stay	May be concurrent or retrospective but usually coincides with awareness of potential loss
Guidelines	Written, explicit, clinically based criteria	Unwritten, implicit criteria (what people think is an "incident")

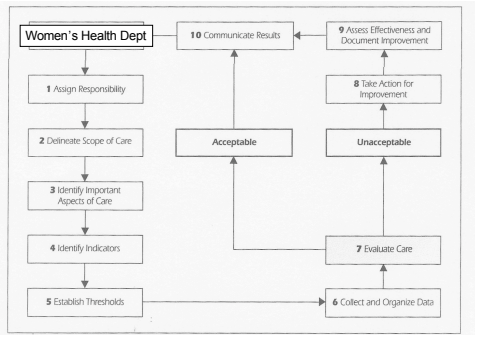
Developing A Program



1) Assign Responsibility

- **Identifies/assigns monitoring responsibilities**
- **Formation of committee**
- **Appointment of members**
- **Consultations**
- **Reporting mechanism**
- **Written plan**

Developing A Program



2) Delineate Scope of Care

Who are the patients?
- What is their age range?
- What are their socioeconomic traits (geographic locale; economic resources; cultural groups; etc)?
- Are there other demographics to consider?

What diagnoses are made and conditions treated?
- What are the common diagnosis related groups (DRGs) and what is each group's average length of stay, Medicare mean length of stay, and payer mix?
- What conditions occur most frequently?

What diagnostic and treatment modalities are commonly required?
- What diagnostic testing is routinely performed?
- What are the most frequent surgical procedures?
- What pharmacologic agents are frequently prescribed?

3) Important Aspects of Care

- **High volume**
  - **Occur frequently**
  - **Affect large number of patients**
- **High risk**
  - **Involve significant risks**
  - **Sentinel events**
  - **Limitation of services**

3) Important Aspects of Care

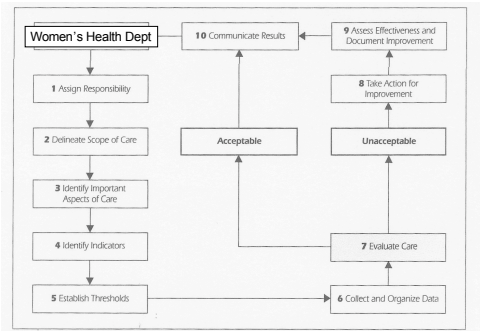
- **Problem prone**
  - **Logistics**
  - **Implementation**
  - **Technical support**
  - **Complex technology**

	Outcomes	Processes
Clinical	Adverse drug reactions	Patient examination
	Patient satisfaction	Medication administration
	Readmission within 72 hours of discharge for same problem	Meal tray preparation and delivery
	Maternal mortality	Patient/family education
Organizational	Regulatory body citation	Product selection
	Delayed discharge	Preventive maintenance
	Procedure delay	Results reporting
	Staff turnover rate/vacancies	Patient registration
		Sequence of test scheduling
		Recruitment procedures

Possible Target Areas

- **History/assessment**
- **STD management**
- **Medication management**
- **Plan/treatment**
- **Progress notes**
- **Pap smear follow-up**
- **Method management**
- **Patient education**

Developing A Program



4) Identify Indicators

- **Sentinel events**
- **Specific rates**
- **Positive/desirable**
- **Negative**
- **Address process/outcome**
- **Considerations**
  - **Approval by staff**
  - **Realistic**

QA/QI In The Office

- **Well suited**
- **Written plan**
- **Meet periodically**
- **Suggested items to monitor**
- **Concentrate on one system**
- **Monitor system**
- **Risk management**

Suggested Items to Monitor for Quality Improvement in the Office

MEDICAL RECORDS/INFORMATION SYSTEMS

- Legibility
- Organization
- Documentation—general (including the problem list)
- Documentation of drug allergy
- Lost medical records
- Misfiled medical records
- Breach of confidentiality
- List of current medications

APPOINTMENTS AND SCHEDULING—PATIENT FLOW

- Acceptable waiting time for appointments
- Appropriate waiting time in office to see clinician
- Follow-up on missed or canceled appointments, tests, and procedures

PATIENT RELATIONS

- Periodic patient survey on perceived quality
- Patient exit evaluation forms
- Evaluation of patient complaints
- Periodic assessment of waiting room reading materials and patient information material for timeliness and appropriateness

PATIENT COMMUNICATIONS

- Compliance with established protocol for informing patient of the results of laboratory studies and procedures
- Method of informing patients of a delayed or rescheduled appointment
- Monitoring appropriateness of method of terminating practitioner–patient relationship

TELEPHONE COMMUNICATIONS

- Excessive busy signals (data are available from the telephone company)
- Excessive holding time

- Documentation of telephone contact in medical records, with disposition documented
- Monitoring of telephone prescription refills for doctor approval
- Monitoring amount of "dropped" or lost calls

PERSONNEL MANAGEMENT

- Employee morale
- Absenteeism
- Periodic employee performance assessment
- Maintenance of patient confidentiality

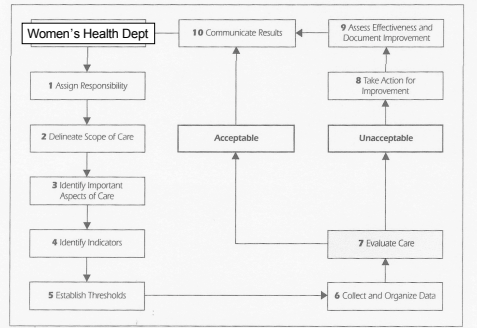
EQUIPMENT AND DRUGS

- Periodic equipment check for proper function
- Maintenance logs of equipment repair
- Security system for controlled drugs
- Security system for syringes and needles
- Method of monitoring drugs for expiration dates (including samples)

COMPLICATIONS AND ADVERSE OUTCOMES OF MEDICAL ACTIVITIES AND PROCEDURES

- Drug reactions
- Wound infections
- Delayed complications from hospitalized patients (eg, episiotomy infections, postpartum endometritis)
- Equipment failure

Developing A Program



5) Establish Thresholds

- **Signals needed for further investigation**
- **Determine when issue is addressed**
- **Based on**
  - **Literature**
  - **National averages**
  - **Local statistical control charts**

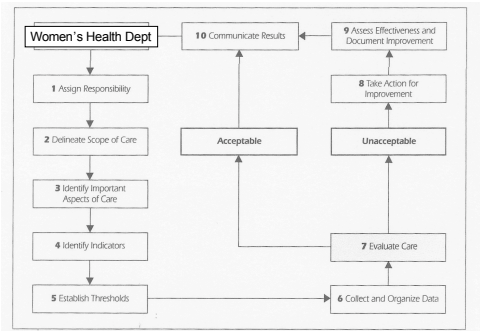
Patient Complaint - Breast

- **A medical record revealed this documentation:**
  - **Patient complained of breast mass before menstruation. Patient counseled to return one week after beginning of next menstrual period for reexamination.**
  - **No other assessment or intervention was included in the documentation regarding this patient's status.**

Best Practices

Do not document a problem or patient symptom without also documenting your assessment and what you did about it.

Developing A Program



Polypharmacy

- **A chart audit revealed this information**
  - **A 30-year-old family planning patient with past medical history of diabetes, hypertension, hypothyroidism, seizures and asthma is seen in the family planning clinic.**

Polypharmacy

- **Drug count included diabetes (three drugs), epilepsy (two drugs), asthma (two inhalers), hypertension (one drug) and hypothyroidism (one drug).**
- **Records indicated last family planning annual visit was 1 year ago to date, when the patient was started on a combined oral contraceptive with physician order.**

Polypharmacy

- **Patient denied any current concerns and all conditions are under fair control.**
- **The medication history was not updated. Patient was issued a year supply of a combined oral contraceptive. No physician order was noted in the chart.**

Review

- **Patient presents with multiple medical problems.**
- **Prior documented medication (9).**
- **Prior physician order for contraceptives.**
- **Documentation approx. 3 lines, indicates patient provided with one year of COCs.**

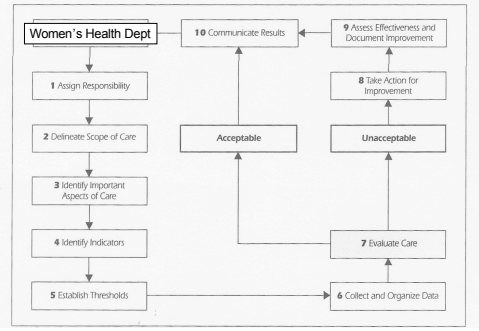
Documentation Problems

- **Medical history update noted in chart? NO**
- **Medication history updated in chart? NO**
- **Annual physician order required to initiate or continue hormonal contraceptive in chart - NO**

Best Practices

- **Update information - medication history, medical history, allergies and any changes at every patient visit.**

Developing A Program



7) Evaluate Care

- **Quality/appropriateness of care**
- **Allows review by non-medical personnel**
- **Generally accepted**
  - **Below - Substandard**
  - **Above - Levels of acceptable care**
  - **Equally acceptable approaches**

[redacted]

Indication: Acute pelvic pain (625.9)

Confirmation of Indication:
Recent onset of pelvic pain of uncertain etiology

Actions Prior to Procedure:[†]
1. Document complete history concerning pain[‡]
2. Confirm by physical exam the presence of abdominal or pelvic tenderness
3. Obtain urinalysis, including microscopic exam
4. Perform pregnancy test for patients of reproductive age
5. Obtain CBC with differential

Contraindication:
[redacted]

Were the following documented in the medical record before the procedure?	Yes	No
1. Patient request for permanent sterilization	☐	☐
2. Informed consent in compliance with appropriate state and federal regulations, including the following:		
a. Alternate forms of contraception	☐	☐
b. Specific procedure to be performed, including failure rate	☐	☐
c. Potential for ectopic as well as intrauterine pregnancy	☐	☐
d. Permanence of procedure	☐	☐
3. Last menstrual period*	☐	☐
4. Negative preoperative pregnancy test*	☐	☐

[redacted]

Procedure: Cone biopsy of cervix, therapeutic (67.2)

Indication: Cervical intraepithelial neoplasia (233.1, 622.1)

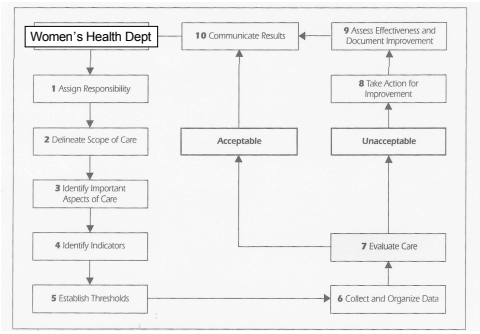
Confirmation of Indication:
Demonstration (by exocervical or endocervical biopsies) of cervical intraepithelial neoplasia without invasion

Actions Prior to Procedure:
1. Perform colposcopy with multiple directed biopsies of the cervix
2. Perform vaginal inspection and biopsy if indicated

[redacted]

of chlamydia

Developing A Program



Preventive Measures

- **Education/training**
  - **Morbidity and mortality conferences**
  - **Seminars**
  - **Case studies**
  - **Equipment demonstrations**
- **Clinical protocols**
  - **Complexity of medicine**
  - **Orient/instruct personnel**
  - **Control costs**
  - **Support staff**

cations may be listed.

Preparation of protocol in a department usually proceeds as follows:

- Recognition of a need
- Review of readily available literature
- Preparation of an initial draft
- Review, revision, and approval by a committee of the department
- Review by nursing staff and any others affected
- Discussion and approval by the department at a full meeting
- Widespread distribution, including members of the risk management and quality assessment programs
- Annual or biennial review with updating as required

Preventive Measures

- **Acquisition of equipment**
  - **Proper indications**
  - **Properly trained**
- **Policy statements**

Abnormal Finding Not Covered In Protocol

- **In one medical record, the nurse documented positive urine dipstick for nitrites and leukocyte esterase on a symptomatic patients and 2+ proteinuria. The progress notes stated "no treatment provided, protocol does no allow for management of 2+ proteinuria".**

Best Practices

Do not write excuses such as "treatment not provided due to…" in the medical record.

ategories of decision on a chart review might include:

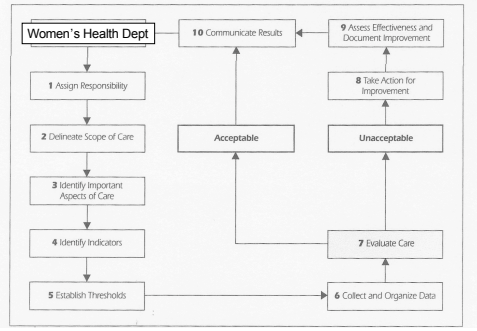
A. No deficiencies found—care appropriate. Morbidity occurred despite appropriate and timely therapy.
B. Opportunity for improvement
   1. Insufficient documentation of care
   2. Incomplete preoperative evaluation or prenatal care
   3. Inappropriate care
      a. Attending physician
      b. House staff
   4. System deficiencies
      a. Nursing
      b. Ancillary services
      c. Other departments (eg, pathology, anesthesiology)
      d. Administration

It is necessary to maintain a record of all actions

Corrective Action

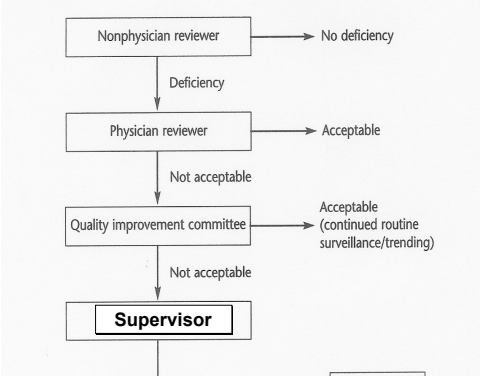
- **Discussion/counseling**
- **Observation of practitioner's skills**
- **Focused education**
- **Proctoring**
- **External peer review**
- **Remedial education**

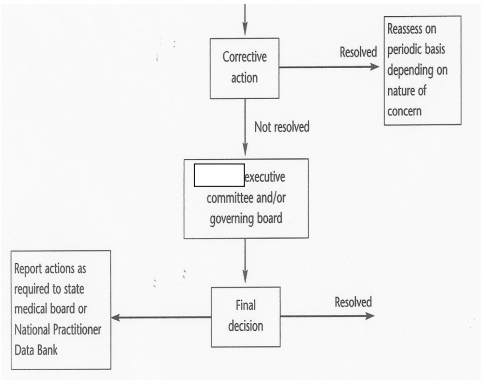
Developing A Program



Corrective Action

- **Reassess problem**
- **Document results**
- **Discuss with legal counsel**





Suggestions

- Develop guidelines
- Training
- Review individual components
- Do not review your own charts
- Allow time for group discussion
- Provide summary report

Correcting Medical Records

- Notification
- Place below last entry
- Explain
- Draw a single line
- Do not out
  - Scratch out
  - White out
  - Write out

Correcting Medical Records

- Timely
- Identify late entry
- Spoilation of evidence
  - Document examination
  - Sanctions
- HIPAA
  - Patient may request correction
  - If disagree must notify and offer Statement of Disagreement
  - Civil and criminal penalties may be assessed
    - Pierce v. Penman, 515 A.2d 948

Correcting Medical Records

- No medical record should be altered or back dated

Informed Refusal

- 27 Ca. 3d 285, 1980.
- Repeatedly advised routine pap smear.
- No documentation of explanations/ potential risks.
- Died from advanced cervical cancer.

Informed Refusal

- Risks and benefits of examination or treatment or both.
- Reasons for recommendations.
- Documentation of description of exam.
- Clarify any misunderstandings/allay fears.

Informed Refusal

- Assure understanding of consequences.
- Document above discussion/informed consent.
- Include reasons for refusal.
- Must take all reasonable steps to secure patients written informed refusal.

Legal and Ethical Conflicts

Peer Review Privilege

- State statues vary in reach and strength
  - Information protected
  - Collaborations protected
  - Absolute versus partial privilege
  - Statutory revocation

Legal Protections

- General evidentiary rules
  - Remedial measures
  - Attorney-client privilege
    - Typically only includes senior management
    - Protection lost if sent to non-party
  - Work product doctrine
    - Jurisdictions differ
    - Protection not absolute

Legal Protections

- Specific Statutes
  - Promise confidentiality
  - Anonymous reporting
  - De-identification of data

Standards

- Create discussion between leadership/staff
  - Blameless and nonpunitive atmosphere
  - Detrimental effect on error reporting/disclosure
  - Provide emotional support

Standards

- Culture of safety
  - Culture of non-tolerance for high error rates
  - Commitment to reducing error
    - Mechanisms to identify and track errors
    - Setting of norms for training and equipment
    - Adoption of practice parameters
- Mandatory disclosure

Final Thoughts

- It's not fun
- Time consuming
- Diligence will pay off

A life is not important except in the impact it has on other lives.

Jackie Robinson

Thanks to

John Banja

Larry Wagner

Laura Dean

Department of Ethics in the Health Professions

ACOG QA/QI in OB/GYN

Emory Risk Management Department

Upcoming Programs

Facing Fear: Crisis Communication and Disaster Behavioral Health
Tuesday, November 15, 2005
12:00-1:30 p.m. (Central Time)

Loss of Bladder Control Across the Adult Population
Thursday, November 17, 2005
2:00-3:00 p.m. (Central Time)

Upcoming Programs

First Aid for the Home Care Worker
Tuesday, November 29, 2005
2:00-4:00 p.m. (Central Time)

Addressing Disaster and Emergency Stress
Monday, December 5, 2005
12:00-1:30 p.m. (Central Time)

For a complete listing:
www.adph.org/alphtn